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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015249
STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2879

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5026 Arlington — Length of stay in 1b: 4 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5026 Arlington — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Hattie Middle: Jeanette Last: Kittel

4. DATE OF DEATH: Month: 3 Day: 19 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 5, 1904

9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): Waterloo, Ills.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: David Miles

13b. MOTHER'S MAIDEN NAME: Sophia Theiss

14. NAME OF HUSBAND OR WIFE: Charles F. Kittel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mr. Chas. F. Kittel, 5026 Arlington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Monocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): 204.2
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 1958 to March 19, 1959. I last saw her alive on Mar 1, 1959
Death occurred at 4:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John B. Shapleigh (Degree or title): M.D.
22b. ADDRESS: 3720 Washington St. Louis
22c. DATE SIGNED: 3/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 3/23/59
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Gardens
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR ADDRESS: Drehmann-Harral, 1905 Union Blvd.
25. DATE RECD. BY LOCAL REG.: MAR 21 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MJB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

Dr. John Shapleigh
3720 Washington
Fr 1-3737

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Albert R. Thompson

Licensed Embalmer No. 4257

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.